

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Ditto.

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 hr.
 Hospital, institution, or street address where death occurred:
289 Frederick St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Roxbury Rd.
 (If rural, give LOCATION)
None
 2.(a) If veteran, name war

3. (a) FULL NAME

John Joseph Allen

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced divorced
 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 12 1890
 6. (c) If alive, give age years

8. AGE: Years 58 Months 2 Days 13 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland.
 (Town, County, and state)

10. Usual occupation Lowyer

11. Industry or business

12. Name Jeremiah Allen

13. Birthplace Rockland Maine

14. Maiden name Mary M Noon

15. Birthplace Ireland

16. Informant Mrs John J Allen

Address Baltimore Maryland,

17. Burial Date thereof 9 28 48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or Rest Haven

Location Hagerstown, Maryland.

18. Funeral director Andrew K. Coffman

Address 40 East Antietam St.

19. Sept. 28, 1948 Registrar
 (Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept/ 24/48 EDT 11:55 at p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death

coronary heart disease
(arteriosclerotic)

Due to acute coronary occlusion

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. no

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

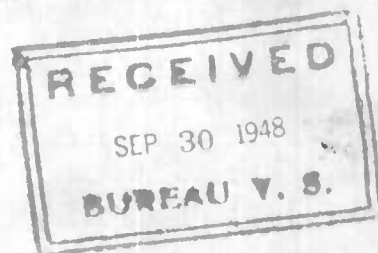
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.

Address Hagerstown, Md. WASH. CO., MD.

Date signed Sept. 27 48



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Clearfloss
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yrs
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Washington
 City or town Clearfloss
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown RD #4
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

JOHN W. AUGHINBAUGH

3. (b) Social Security Number

None4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Sarah Aughinbaugh7. Birth date of deceased (mo., day, yr.) Sept. 6, 18768. AGE: Years 72 Months 5 Days 1 It less than one day hrs. min.9. Birthplace Shippensburg Pa
(town, county, and state)10. Usual occupation Farmer11. Industry or business Farm12. Name Leo Aughinbaugh13. Birthplace Shippensburg14. Maiden name Abigail Truitt15. Birthplace Shippensburg16. Informant Mrs Homer BirneyAddress Hagerstown RD #417. (Burial, cremation, or removal) Which? B Date thereon Sept 10/48
(month) (day) (year)Cemetery or Cedar HillLocation near Greencastle Pa18. Funeral director W. E. MennickAddress Greencastle Pa19. Sept 9, 48 Registrar Robert Boward

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1948 at 3:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23, 1948 to Sept 7, 1948 and that I last saw him alive on September 7, 1948Immediate cause of death Cerebral Thrombosis
DURATION Since July 23

Due to

Due to

Other conditions Previous Thrombosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Lee Reiter M.D.

M. D. or other

Address Remasters - Pa Date signed Sept 7-48

RECEIVED

SEP 12 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:

County... Washington
 City or town... Rural--Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Rural--Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

John D. Baker

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced
Married

8.(b) Name of husband or wife... Mammie Gray Baker
 8.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1870

8. AGE: Years 77 Months 11 Days 12 It less than one day
 _____ hrs. _____ min.

9. Birthplace... Wolfsville-Fred.--Md
 (Town, county, and state)

10. Usual occupation... Retired Farmer

11. Industry or business

12. Name... Unknown
 13. Birthplace... "
 14. Maiden name... "
 15. Birthplace... "

16. Informant... Mrs. Mammie Baker
 Address Harper's Ferry R. D. #1

17. Burial Date thereof... Sept. 28, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Mt. View
 Location... Sharpsburg, Md

18. Funeral director... R. I. Earnshaw

Address... Keedysville, Md
Sept 28 1948
 (1) to be rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 25 19 48, at 5:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 7 19 48 to Sept. 25 19 48
 and that I last saw him alive on Sept. 23 19 48

Immediate cause of death... Chronic Myocarditis
General Edema
Artificial Hypertension

DURATION

1 hr 19 days

Due to... Artificial Hypertension

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE... Shelton Wade, Jr. D.
 M. D. or other

Address... Baltimore Md. Date signed... 9/26/48

RECEIVED
OCT 2 1943
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... 1 Day

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Clearspring
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. #1
(If rural, give LOCATION)2.(a) If veteran, name war... No

3. (a) FULL NAME

Michael Bivens

3. (b) Social Security Number

No

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1948.

8. AGE: Years Months Days It less than one day

0 0 0 1 hrs. min.9. Birthplace... Clearspring, Md. Rt. #1
(Town, county and state)

10. Usual occupation

11. Industry or business

12. Name... Samuel Bivens13. Birthplace... Washington Co. Md.14. Maiden name... Gretha M. Phenix15. Birthplace... Sullivan, Pa.16. Informant... Samuel BivensAddress... Clearspring Md. Rt. #117. Burial Date thereof... Sept 10, 48.
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Luthern CemeteryLocation... Sullivan, Pa.18. Funeral director... Snyder - RowlandAddress... Clearspring Md.19. Sept 9, 48 Charles Brower
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept 9 19 48 at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 8 19 48 to Sept 9 19 48and that I last saw him alive on Sept 9 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations... None.

Date of op.

Autopsy results... None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Paul J. BivensAddress... Clear Spring MdDate signed... 9-9-48

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

09705

1. PLACE OF DEATH:

County WashingtonCity or town Cascade
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 15 days

3. (a) FULL NAME

4. Sex F5. Color or race C6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife James Blackwell7. Birth date of deceased (mo., day, yr.) Nov. 5, 19078. AGE: Years 40 Months 10 Days 20 If less than one day

hrs. min.

9. Birthplace Marion, S. C.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Barnes Blackwell13. Birthplace S. C.14. Maiden name Eliza Jane15. Birthplace S. C.16. Informant Hosp. records

Address

17. Burial Date thereof Sept. 27-48
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Easton wd.Location Talbot Co.18. Funeral director Leon W. HenryAddress Easton wd.19. 9/27 48 N. H. Neer
(Date rec'd by registrar) (year) (month) (day) (name)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)Street No. Port St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 19 48, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 10 19 48 to Sept 25 19 48and that I last saw him alive on Sept 25 19 48Immediate cause of death Carcinoma of Cervix

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. M. Arrington, M.D.Address Ritchie Hospital Date signed 9/25/48Cascade, Md.

RECEIVED
OCT 6 1948
BUREAU V. S.

1948-8-25²¹
46-10-20
1887 11 2-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09706

93d

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months
 Hospital, institution, or street address where death occurred:
436 West Franklin Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 436 West Franklin Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Nettie M. Blair

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 8. (b) Name of husband or wife
 7. Birth date of deceased (mo., day, yr.) July 18, 1868
 8. AGE: Years 80 Months 1 Days 16 If less than one day
 hrs. min.

9. Birthplace Williamsport, Maryland
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Jonathan Spielman

13. Birthplace Hagerstown, Maryland

MOTHER 14. Maiden name Rebecca Bomberger

15. Birthplace Boonsboro, Maryland

16. Informant Mrs. Courtney Myers

Address Sharpsburg, Rt. 1 Maryland

17. Burial Date thereof 9-7-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Funkstown Cemetery

Location Funkstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Sept. 7, 1948 Registrar Chas. Powers
 (Data rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1948 at 48 M

21. I CERTIFY that death occurred on the date above stated - that I attended deceased from Sept. 3, 1948 to Sept. 4, 1948
 and that I last saw him alive on Sept. 4, 1948

Immediate cause of death Coronary Arteriosclerosis

Due to Chronic Myo

Due to Coronary Arterio-sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

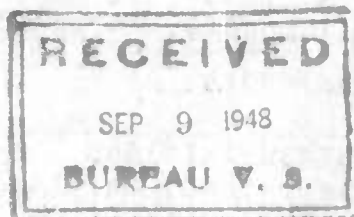
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert B. Brown M.D. M. D. or other

Address Waynesboro Va. Date signed 9/5/48

Mr. Frank Davis



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certifier's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09707 201

1. PLACE OF DEATH:

County Washington
Williamsport, Maryland
 City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 monthHospital, institution, or street address where death occurred:
Ralph Hartle SanatoriumHow long in hospital or institution? 5 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District Of Columbia CountyCity or town Washington D. C.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2. (a) If veteran, name war None

3. (a) FULL NAME

Mrs. Isabel H. Blakelock

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife John W. Blakelock
deceased 6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 1 1868

8. AGE: Years 79 Months 10 Days 28 If less than one day
 hrs. _____ min. _____

9. Birthplace Easton Pa.
 (Town, county, and state)

10. Usual occupation Housewife
Home

11. Industry or business Aaron W Hazen

12. Name Pa.

13. Birthplace Mary Jane Rosenberry

14. Maiden name Pa.

15. Birthplace Pa.

16. Informant Col. H. Blakelock
55 Ingallas Road Monroe Va.
 Address

17. Burial Date thereof Oct. 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Near Arlington Va.

18. Funeral director Edith V. Leaf

Address # 7 Church St. Williamsport, Md.

19. Sept 29 19 48 E Lee McEhoy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 19 48 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 19 48 to Sept 29 19 48
 and that I last saw him alive on Sept 29 19 48

Immediate cause of death _____

Due to Cerebral Occlusion
Arterio Sclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. Lee McEhoy M.D. or other

Address Williamsport Md. Date signed 9/29/48

RECEIVED
OCT 4 1948
BUREAU Y. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

097088

Reg. Dist. No.

1. PLACE OF DEATH:

County..... WashingtonCity or town..... San Juan
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Stromy Memorial Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State..... Maryland County..... WashingtonCity or town..... San Juan
(If outside city or town limits, write RURAL and give nearest town)Street..... Stromy Memorial Home
(If rural, give LOCATION)

2. (a) If veteran, name was.....

3. (a) FULL NAME

Mary Anna Bohm

3. (b) Social Security Number

none

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

Female white single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

Aug 2 - 1873

8. AGE: Years..... Months..... Days.....

It less than one day..... hrs..... min.

75 1 20

9. Birthplace.....

Frederick County, Md.
(Town, county, and state)

10. Usual occupation.....

Boarding House

11. Industry or business.....

Operator

12. Name.....

Daniel Bohm

13. Birthplace.....

Maryland

14. Maiden name.....

Mary E. Perkins

15. Birthplace.....

Maryland

16. Informant.....

Rev. George Foreman

Address.....

Johnsville, Md. R. 1.

17. (Burial, cremation, or removal. Which?).....

Date thereof.....

Burial 9/25/48
(month) (day) (year)

Cemetery or crematory.....

Beaver Dam Cemetery

Location.....

Union Bridge R. 1. Md.

18. Funeral director.....

H. H. Hatcher & Sons

Address.....

Union Bridge & New Windsor, Md.19. Sept 24 1948

(Date rec'd by registrar) Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 22 1948 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 15 1948 to Sept 22 1948and that I last saw him/her alive on Sept 22 1948

Immediate cause of death.....

Chronic Myocarditis.

DURATION.....

1 yr.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

W. L. L. M. D.

Address.....

Bonsbro

Date signed.....

9/22/48

RECEIVED

SEP 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 64½ West Franklin Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Irvin Leroy Burger, Jr.

3. (b) Social Security Number

216-22-9018

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
6. (b) Name of husband or wife		
6. (c) If alive, give age years		
7. Birth date of deceased (mo., day, yr.) <u>October 30, 1929</u>		
8. AGE: Years <u>18</u>	Months <u>10</u>	Days <u>13</u>
If less than one dayhrs.min.		

9. Birthplace Detroit, Mich., U.S.A.
 (Town, county, and state)

10. Usual occupation Student

11. Industry or business

12. Name Irvin L. Burger, Sr.

13. Birthplace Hagerstown, Maryland

14. Maiden name Emma Ensminger

15. Birthplace Williamsport, Maryland

16. Informant Irvin L. Burger, Sr.

Address Hagerstown, Maryland

17. Burial Date thereof 9-15-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Sept. 13, 48
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1948 at 12:50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12/48 and that I last saw him alive on Sept 12/48

Immediate cause of death Fractured skull
Intracranial hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations no

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Sept 9/48

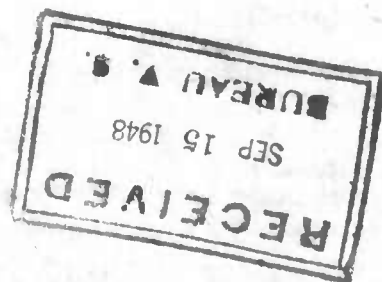
Where did injury occur near Smithsburg Wash. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) public grounds

Means of injury fell off of flagpole (broke)

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.

Address Hagerstown, Md. Date signed 9/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
Garlock Memorial Hospital
 How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 140 West Antietam Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Ella B. Case

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Francis P. Case 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) February 28, 1877
 8. AGE: Years 71 Months 7 Days 2 If less than one day
 hrs. min.

9. Birthplace Warriors Mark, Pa.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business
 FATHER 12. Name Patrick McCann
 13. Birthplace Warriors Mark, Pa.
 MOTHER 14. Maiden name Mary Halligan
 15. Birthplace Warriors Mark, Pa.

16. Informant Miss Louise Case
 Address Hagerstown, Maryland
 17. Burial Date thereof 10-2-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
Hagerstown, Maryland
 Location C. M. Suter & Sons
 18. Funeral director
 Address Hagerstown, Maryland
 19. Oct 1, 1948 Blair H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1948 at 3:15 PM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 29 to Sept. 30 and that I last saw him alive on Sept. 29
 Immediate cause of death Hypertensive Cardiovascular Disease -
Acute Borderline Rubens.
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

DURATION

4 yrs
8 mos.

Major findings of operations..... Date of op.
 Autopsy results no
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE H. Horn George M. D. or other
 Address Hagerstown Md Date signed 10-1-48

RECEIVED

OCT 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County WashingtonCity or town Near Beavercreek
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Near Beavercreek
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war none

3. (a) FULL NAME

Mary Catherine Colvin

3. (b) Social Security Number

none4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife none7. Birth date of deceased (mo., day, yr.) 7-7-1875

6.(c) If alive, give age _____ years

8. AGE: Years 72 Months 10 Days 12 If less than one day _____ hrs. _____ min.9. Birthplace Halfwayville Fred Co ind
(Town, county, and state)10. Usual occupation House Keeping

11. Industry or business

12. Name George William13. Birthplace Poundsville ind14. Maiden name Catharine L. Brunner15. Birthplace Halfwayville Fred Co ind16. Informant Mrs. Irene HoffmanAddress Beavercreek ind17. Burial Date thereof 9-22-1948
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory SmithsburgLocation Smithsburg ind18. Funeral director Geo B HooverAddress Smithsburg ind19. Sept 20 19 48 John H. Bast
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 19 48 at 4 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 19 48 to Sept 19 48and that I last saw him alive on Sept 19 19 48Immediate cause of death Carcinoma of the

DURATION

1 wkDue to Adenocarcinoma of theDue to of course of internal

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John H. Bast M. D. otherAddress John H. Bast Date signed 9/20/48

RECEIVED
SEP 25 1948
BUREAU A. S.

RECEIVED
SEP 22 1948
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09712

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 32 years
 Hospital, institution, or street address where death occurred:
607 Salem Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 607 Salem Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Nora Frances Condon

3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 9. (b) Name of husband or wife William Condon
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept 8, 1868
 8. AGE: Years 80 Months 0 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Frederick County, Maryland
 (Town, county, and state)
 10. Usual occupation Home duties
 11. Industry or business
 12. Name Sanford Cease
 13. Birthplace Frederick County, Maryland
 14. Maiden name Sarah Furgerson
 15. Birthplace Frederick County, Maryland

16. Informant Mrs. Tresa Shaff
 Address 607 Salem Ave Hagerstown, Md.
 17. Burial Date thereof Sept. 24, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Marys Catholic Cemetery
 Location Fairfield, Penna.
 18. Funeral director Fred W. Kraiss
 Address Hagerstown, Maryland

19. Sept 24 48 Health Bowers
 (Data reg'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1948 at 6:00 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 to Sept 21
 and that I last saw him alive on Sept 21

Immediate cause of death Arteriosclerosis - generalized
Arteriosclerosis heart disease
 DURATION 2 yrs -

Due to _____
 Due to _____
 Other conditions Arteriosclerosis - generalized
Arteriosclerosis - heart disease
 (Include pregnancy within 3 months of death) 20 mo.

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Theresa Shaff
 Address Hagerstown Md Date signed 9/24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 131a 09713 300

1. PLACE OF DEATH:

County... WashingtonCity or town... Rural--Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Grace Viola Crampton

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... Harvey F. Crampton6. (c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) March 31, 18878. AGE: Years 61 Months 5 Days 12 If less than one day
..... hrs. min.9. Birthplace... Antietam-Wash.-Maryland
(Town, county, and state)10. Usual occupation... Home Duties

11. Industry or business

12. Name... John W. Boyer13. Birthplace... Antietam, Md14. Maiden name... Ellen Hempsweller15. Birthplace... Woodstock, Virginia16. Informant... Mr. Harvey F. CramptonAddress... Rural-Sharpsburg, Md17. Burial Date thereof... Sept. 15, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Mt. ViewLocation... Sharpsburg, Md18. Funeral director... R. I. EarnshawAddress... Keedysville, Md19-15-48 Ed Boyer
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Rural--Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 12 1948, at 10:45 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 28 1948 to Sept 12 1948
and that I last saw him alive on Sept 12 1948

Immediate cause of death..... DURATION

Cardio-renal vascular disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... GW Llan M.D
M. D. or otherAddress... Bonshors Date signed... 9/13/48

RECEIVED
OCT 7 1948
BUREAU A. S.

RECEIVED
OCT 7 1948
BUREAU A. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09714

304

1. PLACE OF DEATH:

County WashingtonCity or town Hancock
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs.

Hospital, institution, or street address where death occurred:

High Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgesCity or town Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Daniel M⁴Cor Fields Crockett

3. (b) Social Security Number

378-10-5173

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age. _____ years

7. Birth date of

deceased (mo., day, yr.)

JAN. 12, 1874

8. AGE:

Years

Months

Days

If less than one day

74728— hrs.— min.

9. Birthplace

Hancock, Wash. Co., Md.

(Town, county, and state)

10. Usual occupation

Street Car Motorman

11. Industry or business _____

FATHER

12. Name

John W. Crockett

13. Birthplace

Hancock, Md.

MOTHER

14. Maiden name

Mary Elizabeth Beard

15. Birthplace

Hancock, Md.

16. Informant

Mrs. Nancy Vera Stump

Address

Hancock, Md.

17.

Burial

Date thereof

Sept 14, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Thomas Episcopal

Location

Hancock, Md.

18. Funeral director

Charles R. Bast

Address

Hancock, Md.

19.

Sept 14, 1948

(Date rec'd by registrar)

19.

J. A. Veller

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 10, 1948, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 10, 1948, to Sept 10, 1948and that I last saw him alive on Sept 10, 1948

Immediate cause of death

Chronic Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(Country)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

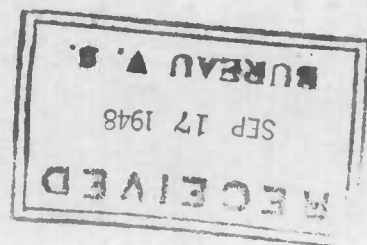
23. SIGNATURE

J. A. Veller

M. D. or other

Address

Hancock, Md.Date signed 9/11/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County WashingtonCity or town Rural-- Williamsport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

Williamsport, Md. RFD# 1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural--Williamsport
(If outside city or town limits, write RURAL and give nearest town)Street No. Williamsport, Md. RFD# 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Viola Stella Cunningham

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Daniel Howe Cunningham

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 6, 1875

8. AGE:

Years

Months

Days

If less than one day

72829

hrs.

min.

9. Birthplace Near Downsville, Wash., Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name George W. Dick13. Birthplace Washington County, Maryland14. Maiden name Ella Hines15. Birthplace Near Rohrsersville, Maryland16. Informant Mr. Arthur CunninghamAddress Williamsport, Md. RFD# 117. burial Date thereof Sept. 8, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Md.18. Funeral director Edith V. LeafAddress Williamsport, Md.19. Sept 8, 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5/48 19..... 21. 10 A.M. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/5/48 19..... to 9/5/48 19.....and that I last saw him living on 9/5/48 19.....Immediate cause of death Chronic DURATION Immediate

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edith V. LeafAddress Williamsport, Md. Date signed 9/5/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 54-9-3
 Hospital, institution, or street address where death occurred:
 483 Mitchell Ave.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 483 Mitchell Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mabel H. Demottez

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife..... Dominic Demottez

6. (c) If alive, give age..... 64 years

7. Birth date of deceased (mo., day, yr.)..... November 27, 1893

8. AGE: Years..... 54 Months..... 11 Days..... 3 If less than one day..... hrs. min.

9. Birthplace..... Hagerstown Wash. Md.

(Town, county, and state)

10. Usual occupation..... House Wife

11. Industry or business..... Own Home

12. Name..... Taylor Shaffer

13. Birthplace..... Va.

14. Maiden name..... Sarah Ponpell

15. Birthplace..... Unknown

16. Informant..... Francis Demottez

Address..... Hagerstown Md.

17. Burial..... Oct 4, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rest Haven Cemetery

Location..... Hagerstown Md.

18. Funeral director..... Scott F. Minnich & Son

Address..... Hagerstown Md.

19. Oct. 2, 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... September 30, 1948 7:15p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1st to Sept 30, 1948 and that I last saw her alive on Sept 30, 1948

Immediate cause of death.....

DURATION

Due to..... Carcinoma of Left Breast? 2 yrs?

Due to..... Breast-

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Hagerstown Md. Date signed..... 10/1/48

RECEIVED

OCT 5 1948

BUREAU V. B.

Evidence for addition

MARYLAND STATE DEPARTMENT OF HEALTH

of birth date and age shown on: 2411 N. Charles St., Baltimore

FILM No. G 117 SEP 16 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred:

Garlock Memorial HomeHow long in hospital or institution? 1 yr

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna County FranklinCity or town Williamson
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

BERTHA A. DETRICH

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.)

1967

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

81

hrs.

min.

9. Birthplace

Penna
(Town, county, and state)

10. Usual occupation

House Keeper

11. Industry or business

Home

FATHER

12. Name

William Detrich

13. Birthplace

Penna

MOTHER

14. Maiden name

Anna Mare

15. Birthplace

Penna

16. Informant

George Detrich

Address

Chambersburg Pa

17.

(Burial, cremation, or removal. Which?)

Date thereof

9-7-48
(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

near Greencastle Pa

18. Funeral director

A E Minnich

Address

Greencastle Pa

19.

(Date read by registrar)

19

48

Class. K. Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 4 1948 at 6 30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

August 19 48 to Sept 4 19 48
and that I last saw her alive on August 23 19 48

Immediate cause of death

congestive heart failure

Due to

chronic kidney disease

Due to

chronic kidney disease

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

David P. Shoop M.D.

M. D. or other

Address

Shoop, Guy, Pa.

Date signed

9/4/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr/ Porterfield

94a

09718

301

Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 years

Hospital, institution, or street address where death occurred:

Williamsport PikeHow long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)Street No. Route # 11
(If rural, give LOCATION)2. (a) If veteran, name war None

3. (a) FULL NAME

EDWARD CALVIN DOUB

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Lillian Grace6. (c) If alive, give age -- years

7. Birth date of

deceased (mo., day, yr.) July 14 1873

8. AGE:

Years

Months

Days

If less than one day

75214

hrs. min.

9. Birthplace Beaver Creek Wash. Co. Md.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Retired12. Name Daniel Doub13. Birthplace Beaver Creek Md.14. Maiden name Catherine Funk15. Birthplace Beaver Creek Md.16. Informant Richard E. DoubAddress Williamsport Md.17. Burial Date thereof 9/30/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Sept 30 19 48 E Lee McCoy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1948 at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 8 19 46 to Sept 28 19 48
and that I last saw him alive on Sept 27 19 48

Immediate cause of death

Coronary Thrombosis

DURATION

9/27/48Due to Hypertensive Vascular Disease ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE H. L. Porterfield

M. D. or other

Address 136 W. Washington Date signed 9/28/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The total age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Wilson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or exact address where death occurred:
Conococheague Park
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County Washington
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Route #1
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Earle Charles Fattman

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ida May Mishick Fattman
 6. (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) January 26, 1923
 8. AGE: Years Months Days If less than one day
25 7 16 hrs. min.

9. Birthplace Washington, Pa.
 (Town, county, and state)

10. Usual occupation Auto Race Driver

11. Industry or business

12. Name Charles H. Fattman

13. Birthplace Pennsylvania

14. Maiden name Edna Phillips

15. Birthplace West Virginia

16. Informant A. Blaine Day

Address Washington Pa.

17. Removal Removal Date thereof 9-13-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory West Bethlehem Cemetery

Location Washington County, Pa.

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Sept 14 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1948 about 5/10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

fractured skull
 Due to open fractures left

10 min

clavicle, left humerus
 Due to left ulna & radius

hemorrhage and shock

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please endorse the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/12/48

Where did injury occur Wilson Wash. Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where) Conococheague Park

Means of injury Racing auto over turned Injured at work

DEPUTY MEDICAL EXAM.

23. SIGNATURE Dr. Robert Wells WASH. CO., MD.

Address Hagerstown, Md. Date signed 9/13/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09720

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
City or town... Hagerstown Ind.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital
How long in hospital or institution? Two hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Penna County... Franklin
City or town... Mercersburg Pa
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. 2
(If rural, give LOCATION)2.(a) If veteran, name war... no

3.(a) FULL NAME

Mrs Ella Louise Frity

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Morris Frity

7. Birth date of deceased (mo., day, yr.)

Dec. 23 - 19266.(c) If alive, give age. 20 years

8. AGE:

Years

Months

Days

If less than one day

21810

hrs.

min.

9. Birthplace

Wash. Co. Ind.
(Town, county, and state)

10. Usual occupation

Home work

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 31948 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended the deceased from

Aug 1 1948 to Sept 3 1948and that I last saw him alive on Sept 3 1948Immediate cause of death Acute cardiaccollapse - probably coronarythrombosis

DURATION

3 hrs.

Due to

Due to

Other conditions

5 1/2 Mrs. Pregnant
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Bowers

M. D. or D.O.

Address Mercersburg, Pa. Date signed 9/5/48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The completed page is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 8 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09721

Reg. Dist. No. 303

1. PLACE OF DEATH:

County WashingtonCity or town Near Hagerstown N.
(if outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State NEW JERSEY County HudsonCity or town Jersey City
(if outside city or town limits, write RURAL and give nearest town)Street No. 67 STORMS AVE

(If rural, give LOCATION)

2. (a) If veteran, name war World War II

3. (a) FULL NAME

LOUIS N GARGIULO

3. (b) Social Security Number

140-18-6191

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

MAY 4, 1925

8. AGE:

Years

Months

Days

If less than one day

23513

hrs.

min.

9. Birthplace

Jersey City Hudson Co. N.J.
(Town, county, and state)

10. Usual occupation

Shipping Dept Manager

11. Industry or business

TONI Home Permanent

12. Name

SABATO GARGIULO

13. Birthplace

ITALY

14. Maiden name

LUCY PANDOLFO

15. Birthplace

N. J.

16. Informant

DANIEL P. GARGIULO

Address

4503 Puller Dr. Kensington Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof Sept 22 1948
(month) (day) (year)

Cemetery or crematory

Holy Name

Location

Jersey City N. J.

18. Funeral director

Thomas De Marco

Address

Jersey City N. J.

19.

(Date rec'd by registrar)

Sept 18 19481948

Registrar

MEDICAL CERTIFICATION

E.D.T.

20. DATE OF DEATH Sept. 17, 1948 19... at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

Fracture of skull
Hemorrhage & shock

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9/17/48Where did injury occur? St. Paul Wash. Md.Highway 9 mile west of Hagerstown, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Auto accident Injured at work? No

23. SIGNATURE

J. Robert Wells

DEPUTY MEDICAL EXAMINER

WASH. CO., MD.

M. D. or other

Address Hagerstown, Md. Date signed 9/18/48

RECEIVED
SEP 21 1948
BUREAU A.S.

RECEIVED
SEP 21 1948
BUREAU A.S.

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Ditto

09722

FILM No. G 117 OCT 13 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Hours
Hospital, institution, or street address where death occurred:
Found Dead In Woods
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 815 Va. Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clarence Gladhill

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife None
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1905

8. AGE: Years 43 Months 8 Days 20 It less than one day hrs. min.

9. Birthplace Hagerstown
(Town, county, and state)

10. Usual occupation Farm Labor

11. Industry or business Farm Labor

12. Name Charles Gladhill

13. Birthplace Hagerstown, Md.

14. Maiden name Louise Eyerly

15. Birthplace Hagerstown, Md

16. Informant Charles Gladhill

Address Hagerstown, Md

17. Burial Date thereof Sept. 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Md

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md

Sept 24 1948 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23-48 19 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23-48 19 Sept 25-48 and that I last saw him on Sept 25-48 19

Immediate cause of death

Heart Abolition

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. W. Sells M. D. or other

Address Hagerstown, Md Date signed 9/24/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Hoffman

09723

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 1/2 years
 Hospital, institution, or street address where death occurred:
220 East Irvin Ave
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 220 East Irvin Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

OWEN LETTELLE GODLOVE

3. (b) Social Security Number

214-09-4047

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Dale Arnold Godlove
 6. (c) If alive, give age 61 years
 7. Birth date of deceased (mo., day, yr.) August 22 1877

8. AGE: Years 71 Months 1 Days 8 If less than one day — hrs. — min.

9. Birthplace Wardensville Hampshire Co. W. Va.
 (Town, county, and state)

10. Usual occupation Construction Foreman

11. Industry or business J. B. Ferguson Co.

12. Name John A. Godlove

13. Birthplace Wardensville W. Va.

14. Maiden name Mary ~~Benson~~ BAUDERMAN

15. Birthplace Woodsboro, Va.

16. Informant Mrs. Dale A. Godlove

Address Hagerstown Md.

17. Burial Date thereof 10/3/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Oct 3, 1948 Chas. H. Brewers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1948 at 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14 1948 to Sept. 30 1948 and that I last saw him alive on Sept. 30 1948

Immediate cause of death Coronary Thrombosis DURATION 1 day

Arteriosclerosis

Due to Duodenal ulcer. 2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

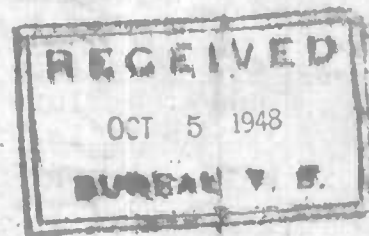
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. H. Brewers M. D. or other

Address Hagerstown Md. Date signed 10/24/48



MARGIN RESERVED FOR BINDING

VS AT5 9-45-15M

360
M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

09724

Reg. Dist. No. 306

1. PLACE OF DEATH
County Washington
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos. 19 days
Hospital, institution, or street address where death occurred: Pitchee Hospital
How long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Croftsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Charles Groomes

3. (b) Social Security Number no

4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Elice Dorsey Groomes
7. Birth date of deceased (mo., day, yr.) 7/8/79
6. (c) If alive, give age 68 years
8. AGE: Years 69 Months 2 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Howard Co., Md.
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business _____

12. Name Frank Groomes
13. Birthplace Glennwood, Md.
14. Maiden name Sally Smith
15. Birthplace Carroll Co., Md.

16. Informant Hosp. records.

Address _____

17. Burial Date thereof Sept 28 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematorium Bushy Park
Location Croftsville Md.

18. Funeral direction Prof W. Barber
Address Croftsville Md.

19. Sept 28 48 Geo W. Ferguson
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 19 48 at 6:57 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 19 48 to Sept 26 19 48
and that I last saw him alive on Sept 26 19 48

Immediate cause of death Cerebral Hemorrhage DURATION 10 min.

Due to Arteriosclerosis ?

Due to _____

Other conditions Previous cerebral hemorrhage & left hemiplegia
(Include pregnancy within 6 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

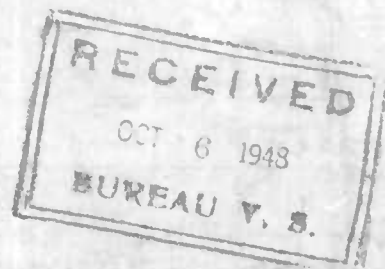
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE J. M. Arington, M.D. M. D. or other
Address Pitchee Hospital Date signed 9/26/48
Croftsville, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bridges

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09725
306

1. PLACE OF DEATH:

County Washington
 City or town Highfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death 30 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md. County Washington
 City or town Highfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Harvey O. Harbaugh

3. (b) Social Security Number

0

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Effie M. Fisher
 6. (c) If alive, give age 83 years
 7. Birth date of deceased (mo., day, yr.) June 14, 1860
 8. AGE: Years 88 Months 3 Days 13 It less than one day _____ hrs. _____ min.

9. Birthplace Chesville Md.
(Town, county, and state)10. Usual occupation Retired

11. Industry or business _____

12. Name Geo. Harbaugh

13. Birthplace _____

14. Maiden name Javilla Brown15. Birthplace Fred. Co., Md.16. Informant Harry L. HarbaughAddress Urbmont, Md.17. Burial Date thereof 9/30/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Green HillLocation Waynesboro Pa.18. Funeral director Walter J. GroveAddress 27 S. Church St., Waynesboro Pa.19. Sep 27 1948 Geo M. Ferguson
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1948 at 11 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-15-1947 to 9/27/48 and that I last saw him alive on 9/27/48Immediate cause of death apoplexy

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE N. C. Bridges

M. D. or other

Blue Bridges Date signed 9/28/48

RECEIVED
OCT 6 1948.
BUREAU V. S.

RECEIVED
OCT 8 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Hoaklander

09726

Reg. Dist. No. 203

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown R # 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Days
 Hospital, institution, or street address where death occurred:
Layman Nursing Home
 How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 553 Salem Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

DARLENE GERTRUDE HARDT

3. (b) Social Security Number

Unable to locate #

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife ---
 7. Birth date of deceased (mo., day, yr.) March 7 1920
 8. AGE: Years 28 Months 6 Days 15 If less than one day --- hrs. --- min.

9. Birthplace Hagerstown Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Waitress
 11. Industry or business Restaurant
 12. Name Tyson T. Hardt
 13. Birthplace Catonsville Md.
 14. Maiden name Rose Coffman
 15. Birthplace Hagerstown Md.

16. Informant Josephine Sprankle
 Address Hagerstown Md.
 17. Burial Date thereof 9/24/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown Md.
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.
 19. Sept. 24 1948 Bar M. Zickler
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1948 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 June 1948 to 22 Sept 1948
 and that I last saw him alive on 19 Sept 1948

Immediate cause of death Carcinoma of cervix DURATION 8 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edwin D. Hoaklander M.D. M. D. or otherAddress Hagerstown Md. Date signed 9/23/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

09727

300

1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 449 N. Jonathan Street
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Madeline Jackson Hardy

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife

6. (c) If alive, give age... years
7. Birth date of deceased (mo., day, yr.) February 24, 1921

8. AGE:

Years 27Months 7Days 2If less than one day
...hrs. ...min.9. Birthplace... Hagerstown, Washington, Md.
(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

FATHER
MOTHER

12. Name

Walter Jackson

13. Birthplace

Shpherdburg, Md.

14. Maiden name

Quindal Strickling

15. Birthplace

Shepherdstown, W. Va.

16. Informant

Mrs. Lucinda Jackson

Address

449 N. Jonathan Street

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

9/29/48
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Md.

18. Funeral director

Address

William H. Downes
291 Greenock St. Hagerstown

19. (Date rec'd by registrar)

19. 48

Sept 29

Registrar

23. SIGNATURE

Robert Vh. Campbell MD
M. D. or other
Address... Hagerstown Md Date signed Sept 28/48

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept 26, 1948, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I deemed

Sept 26, 1948 to some 19
and that I last saw h... alive on Sept 26, 1948

Immediate cause of death

Pulmonary Tuberculosis
generalized

DURATION

Due to

Due to

Other conditions

Central Nervous System
Syphilis
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D. C. 20535

RECEIVED

OCT 1 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 840 Hamilton Blvd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ida M. Hartle

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife S. B. Hartle
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) August 25, 1868
 8. AGE: Years 80 Months 1 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Wash. Co. Md
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name Joseph Bragonier13. Birthplace Hagerstown, Maryland14. Maiden name Susan Spielman15. Birthplace Hagerstown, Maryland16. Informant Mrs. Eugene EvansAddress Hagerstown, Maryland17. Burial Date thereof 10-2-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral Director C. M. Suter & SonsAddress Hagerstown, Maryland19. Oct. 1, 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1948 3:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 17, 1948 to Sept. 30, 1948 and that I last saw him or alive on Sept. 25, 1948

Immediate cause of death

ArteriosclerosisDue to Arteriosclerosis (Stroke)Due to Arteriosclerosis (Stroke)

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations NoneAutopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. Howard Zoeger M. D. or other
Address Hagerstown, Md Date signed 10-1-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 4 1948

BUREAU V. S.

Evidence for change
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09729

Form No. G 117 SEP 21 1948

CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH:

County Washington.

City or town Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days.

Hospital, institution, or street address where death occurred:
Washington County Hospital Hagerstown.

How long in hospital or institution? 5 Days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Williamsport R.F.D.I.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Glendora Effie Hose.

3.(b) Social Security Number

None.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married.

6.(b) Name of husband or wife George Thomas Hose.

6.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Oct. II 1896.

8. AGE: Years Months Days If less than one day
52 II 7 hrs. min.

9. Birthplace Williamsport Md.
(Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business Housewife.

12. Name John Boppe.

13. Birthplace Halfway Md.

14. Maiden name Mary Cunningham.

15. Birthplace Not Known.

16. Informant Mr. George T Hose.

Address Williamsport R.F.D.I.

17. Burial Date thereof Sept 10 48.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or St Pauls.

Location Near Clearspring Md.

18. Funeral director Edith V Leaf.

Address Williamsport Md.

19. Sept 9. 19 48 Clearspring
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 7 19 48 at 11:12 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb. 17 19 47 to SEPT 7 19 48

and that I last saw him alive on SEP T. 7 19 48

Immediate cause of death DIABETIC ACIDOSIS. DURATION 24 hrs.

Due to DIABETES MELLITUS ?

Due to _____

Other conditions DIABETIC GANGRENE

FOOT - RT. 2 WKS.

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE Arthur Robert Cohen M. D. _____

Address Clearspring Md. Date signed 9-9-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

09730

122a

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 Days
 Hospital, institution, or street address where death occurred:
Wash. County Hospital
 How long in hospital or institution? 7 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 343 No. Mulberry St
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

GEORGE LEONARD HOTT

3. (b) Social Security Number

232-01-8203

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Fannie
 6.(c) If alive, give age 41 years
 7. Birth date of deceased (mo., day, yr.) January 13 1904
 8. AGE: Years 44 Months 8 Days 7 If less than one day
 hrs. min.

9. Birthplace Romney Hampshire Co. W. Va.
 (Town, county, and state)
 10. Usual occupation Crane Operator
 11. Industry or business N. Y. Central Iron Wks.
 12. Name John B. Hott
 13. Birthplace Romney W. Va.
 14. Maiden name Ora May Haines
 15. Birthplace Romney W. Va.

16. Informant Joseph A. Hott
 Address Winchester Va.
 17. Bu rial Date thereof 9/22/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
Hagerstown Md.
 Location
 18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

Sept 22 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1948 4 A M
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 14 1948 to Sept. 20 1948
 and that I last saw him alive on Sept. 19 1948
 Immediate cause of death
strangulated rt inguinal
hernia
 DURATION 30hrs
 Due to (gangrenous intestines
and omentum)
 Due to broncho-pneumonia 10 hrs
acute pulmonary artery thrombosis
 Other conditions
herniorrhaphy, resection of bowel
and omentum
 Major findings of operations As above Sept/14/48
 Date of op.

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide No Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE S. Robert Wells M.D. (M. D.)
 Address Hagerstown, Md. Date signed 9/20/48

RECEIVED
SEP 24 1948
BUREAU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Bonshoo
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 68 years
 Hospital, institution, or street address where death occurred:
Potomac St.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Bonshoo
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Potomac St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war no.

3. (a) FULL NAME

Florence Hutzell

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife Single
 7. Birth date of deceased (mo., day, yr.) December - 11 - 1870
 6. (c) If alive, give age 68 years

8. AGE: Years 77 Months 8 Days 25 If less than one day
 hrs. min.

9. Birthplace Cables Cross Road Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business own home

12. Name Adam Hutzell

13. Birthplace Wash. Co. Md.

14. Maiden name Marietta Line

15. Birthplace Wash. Co. Md.

16. Informant J. Maurice Hutzell

Address 105 Broadway Hagerstown Md.

17. Interment Date thereof Sept. 8, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bonshoo Mausoleum

Location Bonshoo Md.

18. Funeral director Wm. J. Best & Son

Address Bonshoo Md.

19. Sept. 8, 1948 John H. Best
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September - 6 - 1948 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 17, 1946 to Sept. 6, 1948
 and that I last saw him alive on Sept. 5, 1948

Immediate cause of death Fracture right femur from a fall
 Due to Arterial Hypertension
General Arteriosclerosis

Due to "
"

Other conditions "
"

(Include pregnancy within 3 months of death)

Major findings of operations "
 Date of op. "

Autopsy results "
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of "

Where did injury occur? (City or town) (County) (State)
" " "

Injured at home, farm, industry, public place (where?) "

Means of injury " Injured at work? "

23. SIGNATURE John H. Best M.D.
 M. D. or other

Address Bonshoo, Md. Date signed 9/7/48

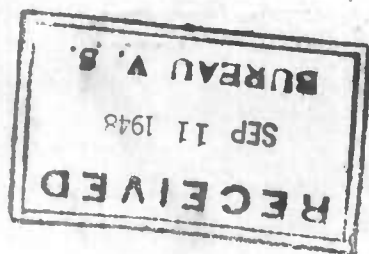
MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wade.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Cascades
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 1/2 months

Hospital, institution, or street address where death occurred:

Ritchie HospitalHow long in hospital or institution? 7 1/2 months

3. (a) FULL NAME

PEARL JAMES

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1905

8. AGE:

43 Years1 Months18 Days

If less than one day

hrs.

min.

9. Birthplace

Darlington, South Carolina
(Town, county, and state)

10. Usual occupation

maid

11. Industry or business

MOTHER FATHER

12. Name

George Washington James

13. Birthplace

Darlington S.C.

14. Maiden name

Martha Washington

15. Birthplace

Darlington, S.C.

18. Informant

Deceased

Address

17. Burial

Burial
(Burial, cremation, or removal. Which?)Date thereof Sept. 19, 1948
(month) (day) (year)

Cemetery or crematory

Abraham Memorial Cemetery

Location

Abraham and

18. Funeral director

Clayton O. Wilson

Address

1000 Beantley ave

19. Date

9/17 19 48A. W. Hedrich
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

1037 Wilcox St

(If rural, give LOCATION)

2. (a) If veteran, name war

✓

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 19 48 at 4:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1, 1948 19 48 to Sept 15 19 48and that I last saw her alive on Sept 15 19 48

Immediate cause of death

Acute pulmonary edema

DURATION

5 min.

Due to

Hypertensive cardiovascular disease

Due to

Other conditions

Left hemiplegia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert A. Moses, M.D.

M.D. or other

Address

Ritchie HospitalDate signed Sept 15, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 209 Summer Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

Elsie N. Kelly

3.(b) Social Security Number

212-24-5718

4. Sex Female 5. Color or race White 6.(a) Single, married, or divorced Widow
 8.(b) Name of husband or wife Bernard Kelly
 8.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 5, 1895
 8. AGE: Years 53 Months 3 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Frederick County, Maryland
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business
 12. Name Louis Plunkert
 13. Birthplace Frederick County, Maryland
 14. Maiden name Annie Hamilton
 15. Birthplace Frederick County, Maryland

16. Informant Miss Betty Kelly
 Address Hagerstown, Maryland
 17. Burial Date thereof 9-13-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland
 18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland
 19. Sept. 12, 1948 Shirley Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9.9.48 at 1:55 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 47 to September 48
 and that I last saw her alive on 9.9.48
 Immediate cause of death Sarcoma

Due to Primary site Fundus Uteri
 Due to
 Other conditions Diabetes Mellitus
 (Include pregnancy within 3 months of death)
 Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?
 23. SIGNATURE Shirley Bowers M. D. or other
148 N. Potomac St. Hagt. Date signed 9.10.48
 Address _____

DURATION
2 months

1 year



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 801

1. PLACE OF DEATH:

County Washington
 City or town Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 Years
 Hospital, institution, or street address where death occurred:
114 West Potomac St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 114 West Potomac
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Blanche Minnie Lizer

3. (b) Social Security Number

None

4 Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Joseph Wesley Lizer
 6.(c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) August 5, 1879
 8. AGE: Years 69 Months 1 Days 7 It less than one day
 hrs. min.

9. Birthplace Oldtown, Allegheny, Maryland
 (Town, county, and state)

10. Usual occupation Housewife
At Home

11. Industry or business

12. Name Don't Know
 13. Birthplace

14. Maiden name Lottie Haugh
 15. Birthplace Oldtown, Md.

16. Informant Charles Lizer
 Address Williamsport, Md.

17. Burial Date thereof Sept. 14, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Riverview Cemetery
Williamsport, Md.
 Location

18. Funeral director Edith V. Leaf
 Address Williamsport, Md.

19. Sept 14 1948 E Lee McElroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1948 at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1948 to Sept. 12 1948
 and that I last saw him alive on Sept. 11 1948

Immediate cause of death

Myocarditis Chronic

Due to

Due to

Other conditions

Branchial Cystoma

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

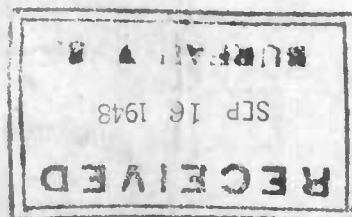
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Lee McElroy M. D. or otherAddress Williamsport Md. Date signed 9/12/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

097735

Reg. Dist. No. 300

1. PLACE OF DEATH:

County Washington County
 City or town Sharpsburg Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Sharpsburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry Leslie Lowman

3. (b) Social Security Number

765-16-4722

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife <u>Ada Baker Lowman</u>		
7. Birth date of deceased (mo., day, yr.) <u>Jan. 13 1885</u>		
8. AGE: Years <u>63</u>	Months <u>8</u>	Days <u>15</u>
If less than one day hrs. _____ min. _____		
6. (c) If alive, give age _____ years		

9. Birthplace Near Sharpsburg, Wash. Md.
(Town, county, and state)10. Usual occupation Machine Shops11. Industry or business W. Md. R. R.12. Name August Lowman13. Birthplace Germany14. Maiden name Ida Criger15. Birthplace Tilghamnton Md.16. Informant Mrs. Ada LowmanAddress Sharpsburg, Md.

17. Burial Date thereof Sept. 30 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. View CemeteryLocation Sharpsburg, Md.18. Funeral director Edith V. LeafAddress Willamsport, Md.

19. Sept 30 1948 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 28 19 48 at 4:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 1, 19 48 to September 19, 19 48

and that I last saw him alive on September 25, 19 48

Immediate cause of death
Coronary thrombosis

DURATION

16 hrs.Due to Arteriosclerotic heart disease. 2 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Henry Aldis M.D.

M. D. or other

Address Shepherdstown, W. Va. Date signed Sep. 30, 1948

RECEIVED
OCT 7 1948
BUREAU A. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH
 County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 yr 4 months
 Hospital, institution, or street address where death occurred:
29. 4 month Wash Co Home
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Smithsburg Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... none
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME
Samuel M. Lowman

3. (b) Social Security Number
none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife none
Smithsburg

7. Birth date of deceased 8-26-1859 8. (c) If alive, give age - years

8. AGE: Years 89 Months 0 Days 14 It less than one day - hrs. - min.

9. Birthplace Smithsburg Md
 (Town, county, and estate)

10. Usual occupation Farmer

11. Industry or business Saimif Lowman

12. Name Saimif Lowman

13. Birthplace Hagerstown Md

14. Maiden name Elizabeth Ann Lowman

15. Birthplace Hagerstown Md

16. Informant Fred. M. Long

Address Hagerstown Md R.F.D. 4

17. Smith Date thereof 9-13-1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Leitchsburg

Location Leitchsburg Md

18. Funeral director Geo. B. Hoover

Address Smithsburg Md

19. Sept. 11, 1948 Registrar Geo. B. Hoover
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10th 1948 at 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1st 1948 to Sept 10 1948
 and that I last saw him alive on Sept 1 1948

Immediate cause of death Cardio-vascular
 Due to renal disease 1 yr.
 Due to Hypertension 1 yr.
 Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op. none

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide none Date of none
 Where did injury occur? none (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) none
 Means of injury none Injured at work? none

23. SIGNATURE Ernest J. Fole M. D. or other none
 Address Hagerstown Md Date signed 9/10/48



1948-8-14
89-0-14
1827-8-26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

158

09737

Reg. Dist. No. 302

I. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Hagerstown, Route # 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

James Russell Mills

3.(b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

July 18, 1948

8. AGE:

Years

Months

Days

If less than one day

023

hrs.

min.

9. Birthplace

Washington County Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

John F. Mills

13. Birthplace

Washington County, Maryland

MOTHER

14. Maiden name

Susan E. Drury

15. Birthplace

Washington County Maryland

16. Informant

Address

John F. Mills
Hagerstown, Route # 2 Md.

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Sept. 23, 1948
(month) (day) (year)

Cemetery or crematory

Clearspring Mennonite Cemetery

Location

Clearspring, Maryland

18. Funeral director

Address

Snyder - RowlandClearspring, Maryland

19.

Sept. 23, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1948 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 15, 1948 to SEPT 21, 1948
and that I last saw him alive on SEPT. 21, 1948

Immediate cause of death

MARASMUS

DURATION

4 1/2

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

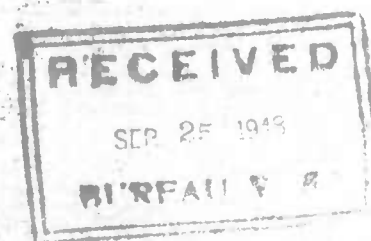
23. SIGNATURE

M. D. or other

Address

Date signed

9-21-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 years
 Hospital, institution, or street address where death occurred:
427 North Prospect Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 427 North Prospect Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

James R. Moore

3. (b) Social Security Number

NONE

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) September 11, 1872
 8. AGE: Years 76 Months 0 Days 17 If less than one day... hrs. ... min.

9. Birthplace Indian Spring, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Retired Farmer

11. Industry or businesses

FATHER
 12. Name Isaac Moore
 13. Birthplace Mooresville, Maryland
 MOTHER
 14. Maiden name Matilda Mills
 15. Birthplace Parkhead, Maryland

16. Informant Mrs. Mary Holtzman
 Address Hagerstown, Maryland

17. Burial Date thereof 10-1-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
 Address Hagerstown, Maryland

19. Sept 30 19 48 Black Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept/28/48 19... at 4:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from... 19... to... 19...
 and that I last saw him... alive on... 19...

Immediate cause of death... DURATION
gun shot (bullet) into

Due to... skull

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations... Date of op...

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Sept/28/48

Where did injury occur? Hagerstown, Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Manner of injury shot self with revolver

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

23. SIGNATURE J. R. Moore M. D. of Washington

Address Hagerstown, Md. Date signed Sept 29/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARITAL STATUS

PREVIOUS ILLNESS

DATE OF ADMISSION

DATE OF DISCHARGE

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF TRANSFER

DATE OF RETURN

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

DATE OF TRANSFER

DATE OF RETURN

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

RECEIVED

OCT 4 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH:

County... WashingtonCity or town... Dargan
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Dargan
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Launa M. Myers

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-------------------------	----------------------------------	--

8. (b) Name of husband or wife... James F. Myers7. Birth date of deceased (mo., day, yr.) Sept. 19, 1897 6. (c) If alive, give age 74 years

8. AGE:	Years	Months	Days	If less than one day
	<u>50</u>	<u>11</u>	<u>21</u>hrs.min.

8. Birthplace... Bakerville Wash. - Md
(Town, county, and state)10. Usual occupation... House Duties

11. Industry or business

12. Name... Charles Boyer13. Birthplace... Sharpsburg, Md14. Maiden name... Catherine Artz15. Birthplace... Fairplay-Md16. Informant... James F. MyersAddress... Harper's Ferry R. F. D. #117. Burial Date thereof... Sept. 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Samples ManorLocation... Dargan, Maryland18. Funeral director... R. J. EarnshawAddress... Keedysville, Md19. 9-10 19 48 W. H. Sharpsburg
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept. 9 19 48 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 45 to 19 48 and that I last saw her alive on Sept. 4 19 48

Immediate cause of death	DURATION
<u>Recurrent Adeno-Carcinoma of the Cervix Uteri</u>	<u>1 yr.</u>
<u>Adeno-Carcinoma of the fundus of the uterus</u>	<u>3 yrs.</u>
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operation... Adeno-Carcinoma of the fundus of the uterus Date of operation... Sept. 1, 1948Autopsy results... None PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

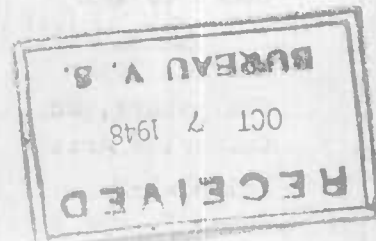
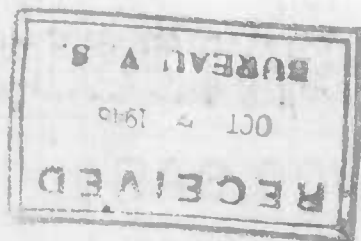
Means of injury Injured at work?

23. SIGNATURE... W. H. Sharpsburg M. D. or other Address... Sharpsburg, Md Date signed... 9/9/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 mos. 23 daysHospital, institution, or street address where death occurred:
Smithmont Convalescent HomeHow long in hospital or institution? 7 mos. 23 days

3. (a) FULL NAME

Victor Myers

3. (b) Social Security Number

NONE4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED6. (b) Name of husband or wife ISABELLE MYERS7. Birth date of deceased (mo., day, yr.) FEB. 5, 1867 8. (c) If alive, give age _____ years8. AGE: Years 81 Months 7 Days 10 If less than one day _____ hrs. _____ min.8. Birthplace REID, WASHINGTON, MD.
(Town, county, and state)10. Usual occupation REAL ESTATE & INSURANCE

11. Industry or business

12. Name DAVID H. MYERS13. Birthplace MD.14. Maiden name CATHERINE LE CRONE15. Birthplace MD.16. Informant ROBERT L. MYERSAddress 20 W. 4TH ST., WAYNESBORO PA.17. BURIAL Date thereof SEPT. 18 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory CEDAR HILL CEMETERYLocation GREENCASTLE, PENNA.18. Funeral director R. J. CarrishawAddress NEEDYSVILLE, MD.19. Sept. 15, 1948 John H. Best
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA. County FRANKLINCity or town WAYNESBORO
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 W. 4TH ST.
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1948 at 1:40 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 15, 1948 to Sept. 15, 1948
and that I last saw him alive on Sept. 14, 1948Immediate cause of death Paralysis Agitans DURATION 1 mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

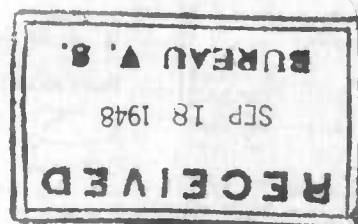
23. SIGNATURE John H. Best M. D. RegistrarAddress Bethesda, Md. Date signed 9/15/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

09741

301

1. PLACE OF DEATH:

County Washington CoCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 wksHospital, institution, or street address where death occurred: Williamsport Sanatorium

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penn County FranklinCity or town Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. RD #1 Greensville Pa

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

ALBERT MARTIN NISWANDER

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Alta Niswander7. Birth date of deceased (mo., day, yr.) Jan 8, 1880

6. (c) If alive, give age _____ years

8. AGE:

6882

if less than one day

hrs.

min.

9. Birthplace

Welsh Run
(Town, county, and state)

10. Usual occupation

minister

11. Industry or business

Church of Brethren

12. Name

Martin Niswander

13. Birthplace

Penn.

14. Maiden name

Elizabeth Meyers

15. Birthplace

Penn.

16. Informant

Glen Niswander

Address

Chamberburg Pa

17.

B Date thereof Sept 13/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

near Greensville

18. Funeral director

R. E. Munich

Address

Greensville Pa

19.

Sept 12, 1948 Chas McShay
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10, 1948 at 4 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 21, 1948 to Sept 10, 1948and that I last saw him alive on Sept 9, 1948

Immediate cause of death

Cardiac decompensation DURATION 10 Mo.

Due to

Multiple Myeloma

Due to

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

David R. Hays M.D.
M. D. or otherAddress Shady Grove Pa Date signed 9/11/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 09742
Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
52 Elizabeth Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 52 Elizabeth Street
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Vienia Elizabeth Norwood

3. (b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
8. (b) Name of husband or wife James H. Norwood
8. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) August 22, 1859
8. AGE: Years 89 Months 1 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Rochester Co. Virginia
(Town, county, and state)
10. Usual occupation At Home
11. Industry or business
12. Name John Davis
13. Birthplace Virginia
14. Maiden name Mary E. Coleman
15. Birthplace Virginia

16. Informant Mrs. William M. Harper
Address Hagerstown, Maryland
17. Burial Date thereof 9-28-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Frederick, Maryland
18. Funeral director M. R. Etchison & Son
Address Frederick, Maryland

19. Sept. 26, 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24/48 19____ at _____ M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-46 19____ to 9/24/48 19____
and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____ DURATION
Congestive Heart Failure 10 wks
Due to _____
Due to _____
Other conditions Hypertensive Disease 5 yrs
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Stacy M. D. M. D. or other
Address Hagerstown, Md Date signed 9/25/48

RECEIVED

SEP 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09743

302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
703 South Potomac Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 703 South Potomac Street
 (If rural, give LOCATION)
First World War
 2. (a) If veteran, name war

3. (a) FULL NAME

John Howard Pearl

3. (b) Social Security Number

214-09-3473

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

7. (b) Name of husband or wife Fren Pearl

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1886

8. AGE: Years 62 Months 0 Days 17 If less than one day
hrs.min.

9. Birthplace Thurmont, Frederick Co. Md.
 (Town, county, and state)

10. Usual occupation Cabinet Maker

11. Industry or business

12. Name Cornelius Pearl

13. Birthplace Maryland

14. Maiden name Katherine O'Connor

15. Birthplace Maryland

16. Informant Mrs. Fren Pearl

Address 703 S. Potomac St. Hagerstown Md

17. Burial Date thereof Oct. 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss

Address Hagerstown, Maryland

19. Sept. 30, 1948 B. H. Sowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1948 7:50 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 17 to September 28 1948
 and that I last saw him alive on September 22 1948

Immediate cause of death Coronary occlusion DURATION 10 minutes

Due to

Due to

Other conditions Coronary arteriosclerosis and thrombosis

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of

Where did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE R. B. Howard M.D. M. D. or other

Address Hagerstown Md Date signed Sept. 30, 1948

RECEIVED

OCT 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09744

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 wks
 Hospital, institution, or street address where death occurred:
Washington Co Hospital
 How long in hospital or institution? 2 wks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pa County Franklin
 City or town Bural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Chambersburg RD 6
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

FREDERICK WALK PICKING

3. (b) Social Security Number

4. Sex

M

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Linda Picking

7. Birth date of deceased (mo., day, yr.)

Aug 15, 1861

6. (c) If alive, give age

83 years

8. AGE:

87

Years

28

Months

Days

If less than one day

hrs. min.

9. Birthplace

Franklin Co Pa
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Farm

FATHER

12. Name

Peter Picking

13. Birthplace

Pa

MOTHER

14. Maiden name

Mary Walk

15. Birthplace

Pa

16. Informant

Lester S Picking

Address

Marion

17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept 15/48
(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

near Greencastle

18. Funeral director

R. E. Munnich

Address

Greencastle Pa

19.

Sept 13, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept 12, 1948

at

6:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug 31, 1948, to Sept 12, 1948

and that I last saw him alive on Sept 12, 1948

Immediate cause of death

Enter shock during
fracture neck of femur
due to fall - accidental

DURATION

Due to

Other conditions

Terminally ill
cardiac failure
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

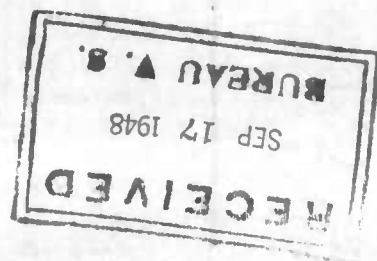
Accident, suicide, or homicide accident Date Aug 30, 1948Where did injury occur? Franklin Co Pa
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) at homeMeans of injury Fell around house Injured at work?

23. SIGNATURE

R. H. Greenbock
Address: 2000 Washington St
Date signed: 9/13/48

M. D. or other

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09745

302

1. PLACE OF DEATH:

County..... Washington
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:
711 Oak Hill Avenue
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 711 Oak Hill Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Gladys Belle Poole

3. (b) Social Security Number

NONE

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... June 24, 1903
 8. AGE: Years..... 45 Months..... 2 Days..... 9 If less than one day..... hr. min.

9. Birthplace..... Hagerstown, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation..... Art Teacher
 11. Industry or business..... Woodland Way School
 12. Name..... Daniel E. Poole
 13. Birthplace..... Washington County, Md.
 14. Maiden name..... Anna D. Brewer
 15. Birthplace..... Washington County, Md.

16. Informant..... Dr. Ernest Poole
 Address..... Hagerstown, Maryland
 17. Burial..... Burial Date thereof..... 9-4-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Rose Hill Cemetery
 Location..... Hagerstown, Maryland
 18. Funeral director..... C. M. Suter & Sons
 Address..... Hagerstown, Maryland

19. Sept 4, 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sept 2nd 19 48 at 2:30 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 11 19 47 to Sept 2nd 19 48
 and that I last saw her alive on Sept 2 19 48
 Immediate cause of death.....

	DURATION
<u>Carcinoma Cervix</u>	<u>1yr-1mo</u>
Due to..... <u>Anaemia Secondary</u>	<u>8mo</u>
Due to..... <u>Cachexia</u>	<u>4mo</u>
Other conditions.....	

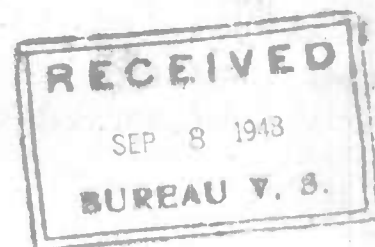
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... Ernest J Poole MD M. D. or other
 Address..... Hagerstown, Md Date signed..... 9/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09746

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? _____
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Martha Grayson Pry

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced
Widowed

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1948 at 8:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 5 1948 to Sept 16 1948
 and that I last saw her alive on Sept 16 1948

Immediate cause of death

nocturnal heart of 2 years - left
coronary artery disease

DURATION

11 days
2 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Sept 16 1948
 Where did injury occur? Hagerstown (City or town) Wash. (County) Md (State)

Injured at home, farm, industry, public place (where?) Nursing home 740PMeans of injury fell out of bed Injured at work? No 740P23. SIGNATURE Philip H. Egan M. D. or otherAddress Hagerstown Md Date signed 9/2/486.(b) Name of husband or wife Charles A. Pry

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 29, 1865

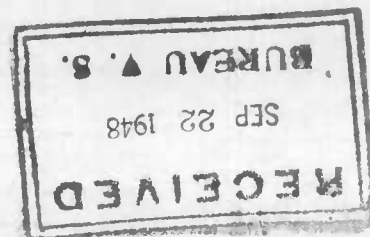
8. AGE: Years 83 Months 4 Days 18 If less than one day
 _____ hrs. _____ min.

9. Birthplace Luray--Paige--Virginia
 (Town, county, and state)10. Usual occupation Home Duties

11. Industry or business _____

12. Name Benjamin F. Grayson13. Birthplace Luray, Virginia14. Maiden name Caroline Seibert15. Birthplace Luray, Virginia16. Informant Miss Louise PryAddress Hagerstown, Md17. Burial Date thereof Sept. 19, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. ViewLocation Sharpsburg, Md18. Funeral director R. I. EarnshawAddress Keedysville, Md19. Sept. 17, 1948 Registrar
 (Date rec'd by registrar)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09747

73d

302

1. PLACE OF DEATH: Washington
County.....
City or town.....Funkstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
WS West Side Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town.....Funkstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. WS West Side Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME
Mary Elizabeth Reeher

3.(b) Social Security Number
NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
8.(b) Name of husband or wife Lewis F. Reeher
8.(c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.) December 9, 1871
8. AGE: Years 76 Months 10 Days 8 If less than one day.....hrs.min.

9. Birthplace Hancock, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

12. Name Denton Malott
13. Birthplace Hancock, Maryland
14. Maiden name Mary Welsh
15. Birthplace Funkstown, Maryland

16. Informant Lewis F. Reeher
Address Funkstown, Maryland

17. Burial Burial Date thereof 9-20-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Funkstown Cemetery
Location Funkstown, Maryland

18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland

19. Sept. 20 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1948 at 2:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1948 to Sept 17 1948
and that I last saw her alive on Sept 17 1948
Immediate cause of death Cerebral Hemorrhage
DUE TO Hypertensive Cardio-vascular Disease
DUE TO Vascular Disease
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

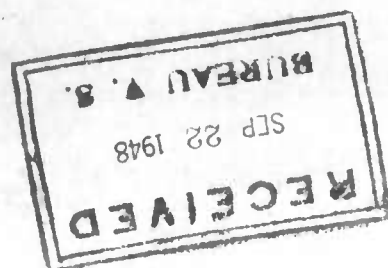
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Manner of injury..... Injured at work?

23. SIGNATURE J. H. Hovestem M.D. or other
Address Funkstown Md Date signed 9/17/48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hyagesstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Hyagesstown HospitalHow long in hospital or institution? 2 days

3. (a) FULL NAME

Franklin Eugene Pidenour

3. (b) Social Security Number

4. Sex

m.

5. Color or race

w.

6. (a) Single, married, widowed, or divorced

S.

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1948

8. AGE:

Years

Months

Days

If less than one day

4

..... hrs. min.

9. Birthplace

Waynesboro, Pa.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
MOTHER

12. Name

Edward D. Pidenour

13. Birthplace

Edgmont, Md.

14. Maiden name

Margaret Miller

15. Birthplace

Smithsburg Md.

18. Informant

Mr. Edward D. Pidenour

Address

Smithsburg Md. #2

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Smithsburg Cemetery

Location

Smithsburg Md.

18. Funeral director

Walter G. Gove

Address

278 Church St. Waynesboro Pa.

19.

Sept. 7, 1948

19.

Blackshears

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wash.City or town Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Smithsburg Md. #2

(If rural, give LOCATION)

2. (a) If veteran, name war Smithsburg Md. #2

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 19 48, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sunday Sept. 5 19 48, to Sept. 7 19 48and that I last saw him alive on Sept. 7, 1948 19 48Immediate cause of death atolactasis glang

DURATION

Due to Hernia of diaphragm(strangulated)Due to —Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations strangulated herniaResection of diaphragm Date of op. 9-6-48Autopsy results Hernia of diaphragm and atolactasis glang

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of M

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Shitoy YINGAddress Washington County Hosp. M. D. another

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

RECEIVED

SEP 9 1948

BUREAU V. S.

Evidence for change of
birth date shown on:

FILM No. G 117 OCT 13 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Sullivan

740 V

05749

Reg. Dist. No. 302

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Weeks

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 11 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 402 Mitchell Ave
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

RICHARD EDWARD SCHLOTTERBECK

3. (b) Social Security Number

None

4. Sex N Male 5. Color or race White 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife ---

6. (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) September 23 1948 1944

8. AGE: Years 4 Months 0 Days 3 If less than one day --- hrs. --- min.

9. Birthplace Hagerstown Wash. Co. Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business ---

12. Name Harry E. Schlatterbeck

13. Birthplace Hagerstown Md.

14. Maiden name Anita Owens

15. Birthplace Hagerstown Md.

16. Informant Harry E. Schlatterbeck

Address Hagerstown Md.

17. Burial Date thereof 9/30/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Sept 30, 48 Registrar Charles Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1948 at 7.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-9 19 48 to 9-27 19 48
and that I last saw him alive on 9-27 19 48

Immediate cause of death

Acute myocardial infarction

DURATION

3 mos

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Leukemia Date of pp. 8-16-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

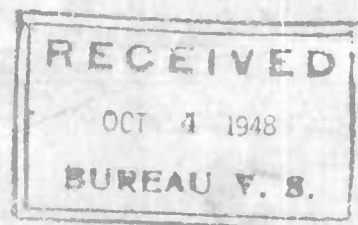
23. SIGNATURE

J. Margaret Sullivan M.D. M. D. or other
Address 135 N. Potters St Date signed 9-28-48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Novenstein

09750

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 days
 Hospital, institution, or street address where death occurred:
Wash. Cty. Hospital
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 511 Maryland Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Edwin Alexander Scott

3. (b) Social Security Number

214-16-1640

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Mabel
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Dec. 15, 1898
 8. AGE: Years 49 Months 9 Days 25 It less than one day hrs. min.

9. Birthplace Upperville, Fauquier, Va.
 (Town, county, and state)
 10. Usual occupation Buttermaker
 11. Industry or business Superior Dairy Co.
 12. Name Alexander Scott
 13. Birthplace Marshall, Va.
 14. Maiden name Della Sinclair
 15. Birthplace Marshall, Va.

16. Informant Mrs. Edwin Scott
 Address 511 Maryland Ave.
 17. Burial Date thereof Sept. 12, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Md.
 18. Funeral director A. K. Coffman
 Address Hagerstown, Md.
 19. Sept 11 19 48 Black Hovers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 6, 1946 to Sept 10, 1948
 and that I last saw him alive on Sept 10, 1948
 Immediate cause of death Lymphosarcoma

DURATION

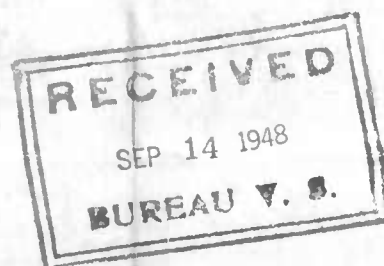
Mar 6 - 1946

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Sedney Novenstein MD
 M. D. or other
 Address Unknown MD Date signed 9/11/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wade

93d Be 09751

Reg. Dist. No. 305

1. PLACE OF DEATH:

County... Washington
 City or town... Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Weeks
 Hospital, institution, or street address where death occurred:
Guilford Nursing Home
 How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County.....
 City or town... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 3632 Elm St
 (If rural, give LOCATION)
 2.(a) If veteran, name war... None ✓

3. (a) FULL NAME

MRS IDA BARR SMITH

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Esten A. Smith
 6.(c) If alive, give age 81 years
 7. Birth date of deceased (mo., day, yr.) February 8 1867
 8. AGE: Years 81 Months 7 Days 12 It less than one day
 hrs. min.

9. Birthplace Breathesville Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home

FATHER 12. Name Cullen Barr
 13. Birthplace Hagerstown Md.
 MOTHER 14. Maiden name Catherine E. Doub
 15. Birthplace Hagerstown Md.

16. Informant Esten A. Smith
 Address Boonsboro Md.

17. Burial Date thereof 9/22/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Chewsville Cemetery
 Location Chewsville Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. Sept. 20. 19 48 John H. Bast
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1948 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 5th 19 48, to Sept. 20th 19 48
 and that I last saw him alive on Sept. 19th 19 48

Immediate cause of death
Sen. heart. Hemorrhage
Chronic myocarditis
Arterial atherosclerosis
 Due to.....
 Due to.....

Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Shelton Wade M. D. on October
 Address Boonsboro, Md. Date signed 9/20/48

DURATION
1.5 days
1.5 days



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

09752

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Hours

Hospital, institution, or street address where death occurred:

Maryland Ribbon Co.How long in hospital or institution? 5 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 105 E. Washington St

(If rural, give LOCATION)

2(a) If veteran, name war None

3. (a) FULL NAME

PAUL EDGAR SPALDING

3. (b) Social Security Number

214-09-6697

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

MarriedB. (b) Name of husband or wife Grace E.B. (c) If alive, give age 58 years

7. Birth date of

deceased (mo., day, yr.) December 8 1888

8. AGE:

Years 59 Months 7 Days 19 If less than one day
hrs. min.9. Birthplace Point of Rocks Fred. Co. Md.

(Town, county, and state)

10. Usual occupation Loom Mechanic11. Industry or business Md. Ribbon Co.12. Name Howard J. Spalding13. Birthplace Frederick Md.14. Maiden name Hattie Nichols15. Birthplace Point of Rocks Md.16. Informant Mrs. Grace E. SpaldingAddress Hagerstown Md.17. Burial Burial Date thereof 9/30/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Roscoe Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. Sept. 30 48 Charles Howard
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1948 at 3:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19Immediate cause of death arteriosclerotic coronary

DURATION

Due to heart diseaseDue to acute coronary occlusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results no Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

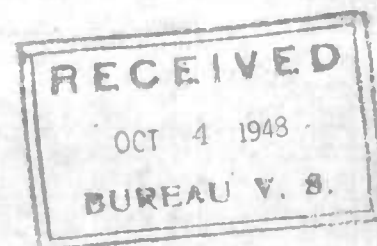
Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Dropped dead at work

Means of injury Injured at work?

23. SIGNATURE Dr. Robert Wells DEPUTY MEDICAL EXAM.Address Hagerstown, Md. WASH. CO., MD.
Date Sept. 28. 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 191a

Reg. Dist. No.

09753

303

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
Hagerstown Route # 2
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerstown Route # 2
 (If rural, give LOCATION)
 2(a) If veteran, name war

3. (a) FULL NAME

Clara Mae Ida Sprecher

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ira Sprecher
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) December 23, 1883
 8. AGE: Years 64 Months 8 Days 21 If less than one day _____ hrs. _____ min.

9. Birthplace Washington County Maryland
 (Town, county, and state)
 10. Usual occupation Home Duties
 11. Industry or business
 12. Name Daniel M. Grove
 13. Birthplace Washington Co. Maryland
 14. Maiden name Reciha C. Stech
 15. Birthplace Lancaster Co. Penna.

16. Informant Mr. Ira Sprecher
 Address Hagerstown, Route # 2
 17. Burial Date thereof Sept. 15, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory St. Pauls Cemetery
 Location Hagerstown Route # 2
 18. Funeral director Snyder - Rowland
 Address Clearspring, Maryland

19. Sept 18 19 48 Dr. M. Zepher
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Sept 19 48 at 7:30 A. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Sept 19 48 to 13 Sept 19 48
 and that I last saw her alive on 12 Sept 19 48

Immediate cause of death Cerebral Hemorrhage
 DURATION 4 days

Due to Hypertensive C.V.R. Disease 10 yr +

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. J. Lusby M. D. or other
 Address 2301 P. Thomas Date signed 15 Sept 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County **Washington**
City or town **Williamsport**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **31 years**
Hospital, institution, or street address where death occurred:
17 South Vermont St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State **Maryland** County **Washington**
City or town **Williamsport**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **17 South Vermont**
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Blanche Antress Stevens

3. (b) Social Security Number

None

4. Sex Female	5. Color or race White	6. (a) Single, married, widowed, or divorced Divorced
6. (b) Name of husband or wife Bear		
7. Birth date of deceased (mo., day, yr.) Sept. 26, 1897		
8. AGE: Years 50	Months 11	Days 27
It less than one day hrs. min.		

9. Birthplace **Fulton County, Pennsylvania**
(Town, county, and state)
10. Usual occupation **Housewife**
11. Industry or business **At Home**

12. Name **Joshiah Stevens**
13. Birthplace **Fulton County, Pennsylvania**
14. Maiden name **Mary Catherine Trumpower**
15. Birthplace **Fulton County, Pennsylvania**
John Stevens

18. Informant **Williamsport, Md.**
Address

17. **Burial** Date thereof **Sept. 26, 1948**
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory **Greenlawn Cemetery**
Location **Williamsport, Md.**

18. Funeral director **Edith V. Leaf**
Address **Williamsport, Md.**

19. **Sept 26 1948** Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH **9/23/48** 19 **48** at **5:50 P. M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **9/23/48** to **9/23/48** and that I last saw him alive on **9/23/48**

Immediate cause of death **Carcinoma Cervix uteri with metastasis**

DURATION **2 yrs.**

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **A. F. Gorman**
Address **Williamsport, Md.** Date signed **9/24/48**

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:
39 Paper Mill Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 39 Paper Mill Road
 (If rural, give LOCATION)
 2. (d) If veteran, name war

3. (a) FULL NAME

Hester A. Stevens

3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow6. (b) Name of husband or wife George Stevens

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 18708. AGE: Years Months Days If less than one day
78 3 14 hrs. min.9. Birthplace Williamsport, Maryland
(Town, county, and state)10. Usual occupation Housework

11. Industry or business

12. Name George Williamson13. Birthplace Williamsport, Maryland14. Maiden name Susan Love15. Birthplace Williamsport, Maryland16. Informant Mrs. Joseph McPhersonAddress Hagerstown, Maryland17. Burial Date thereof 9-28-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland19. Sept 27 48 Pharrell Powers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 19 48 at 9:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1948 to Sept 25 19 48
and that I last saw h. su alive on Sept 27 19 48Immediate cause of death Conc. of hemorrhage on thrombosis DURATION 1 Mon.Due to Thromb. Arteriosclerosis 5 years

Due to

Other conditions Hypertension 2 years ago

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. B. Campbell M. D. or otherAddress Hagerstown Md. Date signed Sept 28 48

RECEIVED

SEP 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK! Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09756

93d

EOD

1. PLACE OF DEATH:

County Washington
 City or town Sharpsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 Years
 Hospital, institution, or street address where death occurred:
Chatman Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Agersstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Chatman Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Lucy Ann Steward

3. (b) Social Security Number

4. Sex Female 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Henry Steward
 7. Birth date of deceased (mo., day, yr.) September 17, 1871
 6. (c) If alive, give age 75 years
 8. AGE: Years 77 Months 11 Days 29 It less than one day
 hrs. min.

9. Birthplace King George County, Va.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business

12. Name Richard Williams
 13. Birthplace King George County, Va.
 14. Maiden name Unknown
 15. Birthplace

16. Informant Viola Mae Steward
 Address 112 W. Bethel Street

17. Burial Data thereof 9/21/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Agersstown, Md.
 Location

18. Funeral Director William H. Owens
 Address 29 Frederick St. Hagerstown

19. Sept. 21, 1948
 (Date read by registrar) Registrar E. J. Boyer

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1948 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19... 19... 19...
 and that I last saw him... alive on... 19...

Immediate cause of death Chronic Myocarditis
 Duration 5 yrs

Due to...
 Due to...

Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...

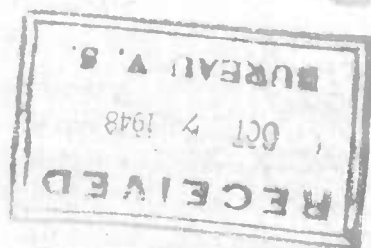
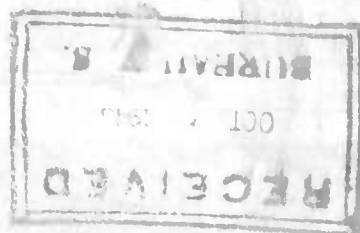
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE GW Boyer MD
 M. D. or other

Address Boonsboro Date signed 9/20/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

De. Lusby

09758

Reg. Dist. No. 302

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>39 Years</u> Hospital, institution, or street address where death occurred: <u>51 East Antietam,</u> How long in hospital or institution? <u>39 Years</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>51 East Antietam</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>None</u>	
3. (a) FULL NAME <u>Samuel P. Thomas</u>		3. (b) Social Security Number <u>No</u>	
4. Sex <u>Male</u> 5. Color or race <u>White</u> 6. (a) Single, married, widowed, or divorced <u>Widower</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>Laura V.</u> 7. Birth date of deceased (mo., day, yr.) <u>October 12, 1863</u> 8. AGE: Years <u>84</u> Months <u>8</u> Days <u>22</u> (If less than one day, hrs. min.) 9. Birthplace <u>Hagerstown, Md.</u> (Town, county, and state) 10. Usual occupation <u>Sect. Central Chemical Corp.</u> 11. Industry or business <u>Retired</u>		20. DATE OF DEATH <u>Sept. 6,</u> 19 <u>48</u> at <u>4:30 P</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>4 Sept</u> to <u>6 Sept</u> and that I last saw him alive on <u>6 Sept</u> Immediate cause of death <u>arterio-sclerosis C-V-R disease</u> DURATION <u>10 yr +</u> Due to _____ Due to _____ Other conditions _____ (Include pregnancy within 3 months of death) Major findings of operations <u>MI</u> Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.	
MOTHER 12. Name <u>Jacob B. Thomas</u> 13. Birthplace <u>Chewsville, Md.</u> 14. Maiden name <u>Nancy Long</u> 15. Birthplace <u>Chewsville, Md.</u>		22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____	
FATHER 16. Informant <u>Mrs. Mary Bowman</u> Address <u>Hagerstown, Md.</u>		23. SIGNATURE <u>J. J. Lusby</u> Address <u>2300 P Street</u> Date signed <u>7 Sept 48</u>	
17. Burial <u>Burial</u> Date thereof <u>Sept. 8, 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Rose Hill Cemetery</u> Location <u>Hagerstown, Md.</u>		18. Funeral director <u>A. K. Coffman</u> Address <u>Hagerstown, Md.</u>	
19. (Date rec'd by registrar) <u>Sept. 8, 1948</u> Registrar <u>Blasf. Boward</u>			

RECEIVED

SEP 10 1948

BUREAU V. S.

RECEIVED

SEP 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

09757

302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 years

Hospital, institution, or street address where death occurred:

Washington County JailHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Brookline Ave. R.D. # 1
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Alta Tracy

3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife Charles O. Tracy

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19, 18998. AGE: Years Months Days If less than one day
49 7 28 hrs. min.9. Birthplace Frederick County, Maryland
(Town, county, and state)10. Usual occupation Home Duties

11. Industry or business

12. Name Dallas Misner13. Birthplace Frederick Co. Md.14. Maiden name Rosie C. Green15. Birthplace Frederick County, Maryland16. Informant Mrs. Elizabeth WetzelAddress Hagerstown, Maryland17. Burial Date thereof Sept. 20, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Bethel CemeteryLocation Near Garfield, Maryland18. Funeral director Fred W. KraissAddress Hagerstown, Maryland19. Sept. 20 48 Blackthorn
(Date rec'd by registrar) RegistrarMEDICAL CERTIFICATION about R.D.T.20. DATE OF DEATH Sept. 17, 1948 at 1:30 A

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

DURATION

Suffocation by hanging

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 9/17/48Where did injury occur? Hagerstown Wash. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Wash. Co. JailMeans of injury Hanged self Injured at work? No23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.Address Hagerstown, Md. WASH. CO., MD.Date signed 9/20/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

73

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 97

Reg. Dist. No. 303

1. PLACE OF DEATH:

County... Washington
 City or town... Ernstville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Washington
 City or town... Ernstville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Clarence Grant Turner

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
6. (b) Name of husband or wife... <u>Bessie Turner</u>		
6. (c) If alive, give age years		
7. Birth date of deceased (mo., day, yr.) <u>May 2, 1889</u>		
8. AGE:	Years <u>59</u>	Months <u>4</u>
	Days <u>24</u>	If less than one day hrs. min.

9. Birthplace... Luray, Va.
 (Town, county, and state)
 10. Usual occupation... Farmer
 11. Industry or business... Farming
 12. Name... Grant Turner
 13. Birthplace... Virginia
 14. Maiden name... Nancy Painter
 15. Birthplace... Virginia
 16. Informant... Mrs. John Reed
 Address... Big Pool, Md.

17. Burial Date thereof... Sept. 28, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Shanktown Cemetery
 Location... Big Pool, Md.
 18. Funeral director... Snyder-Rowland
 Address... Hancock, Md.

19. Sept 28 19 48 Joseph W. Murray Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... September 26, 1948 at 2 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
JUNE 2, 1948 19... to SEPT. 26, 1948
 and that I last saw h... 1M alive on SEPT. 25, 1948 19...

Immediate cause of death	DURATION
<u>CEREBRAL VASCULAR DISEASE</u>	<u>4 YEARS</u>
<u>CAUSE UNDETERMINED.</u>	
<u>XXX CARDIAC FAILURE</u>	<u>3 DAYS</u>

Due to
 Other conditions
 (Include pregnancy within 3 months of death)
 Major findings of operations... NONE Date of op.
 Autopsy results... NONE
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... Arthur Robert Cohen M. D. 9-27-48
 Address... Clear Spring, Md. Date signed...

RECEIVED

SEP 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 47 years

Hospital, institution, or street address where death occurred:

31 Fenton Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)Street No. 31 Fenton Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Myrtle Frances Turner

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
6.(b) Name of husband or wife <u>Richard Preston Turner</u>		
6.(c) If alive, give age <u>71</u> years		
7. Birth date of deceased (mo., day, yr.) <u>October 14, 1868</u>		
8. AGE: Years <u>79</u>	Months <u>11</u>	Days <u>11</u> hrs. min.

9. Birthplace Near Downsville, Wash., Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business At Home12. Name Jacob Wolford
13. Birthplace Pennsylvania14. Maiden name Mary Ellen Poppe
15. Birthplace Pennsylvania16. Informant Richard Preston Turner
Address Williamsport, Md.17. Burial Date thereof Sept. 27, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Greenlawn, CemeteryLocation Williamsport, Md.18. Funeral director Mrs. Edith V. LeafAddress Williamsport, Md.19. Sept-27 19 48 Mrs. E. Lee McElroy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25/48 19 48 at 4:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/25/48 19 48 to 9/25/48 19 48and that I last saw her alive on 9/25/48 19 48Immediate cause of death BronchitisDecubitus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE A. P. Gougeon M. D. or otherAddress Williamsport, Md. Date signed 9/27/48

RECEIVED

OCT 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 803

1. PLACE OF DEATH:

County Washington
 City or town Clearspring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Clearspring
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Clearspring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. None
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lda Ellen Ward

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>	
6. (b) Name of husband or wife <u>Dallas L. Ward</u>			
6. (c) If alive, give age _____ years			
7. Birth date at deceased (mo., day, yr.) <u>November 20, 1863</u>			
8. AGE:	Years <u>84</u>	Months <u>10</u>	Days <u>1</u> It less than one day _____ hrs. _____ min.
8. Birthplace <u>Washington County Maryland</u> (Town, county, and state)			
10. Usual occupation <u>Home duties</u>			
11. Industry or business			
FATHER	12. Name <u>Jacob Shank</u>		
	13. Birthplace <u>Maryland</u>		
MOTHER	14. Maiden name <u>Angeline Eddie</u>		
	15. Birthplace <u>Maryland</u>		

16. Informant Mrs. Fred Kuhn
 Address Clearspring, Maryland
 17. Burial Date thereof Sept. 25, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Paul's Cemetery
 Location Western Pike
 18. Funeral director Snyder - Rowland
 Address Clearspring, Md.
 19. Sept 25 19 48 Joseph W. Murray
 (Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1948 19 11:15 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 _____ to Sept 21, 1948
 and that I last saw him alive on Sept 20, 1948
 Immediate cause of death

	DURATION
<u>Cerebral Sclerosis</u>	<u>3 years</u>
<u>Arterio Sclerosis</u>	<u>10 years</u>
<u>Arterial Hypertension</u>	

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 _____ Date of op. _____Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE David P. Brewer M.D. M. D. or other
 Address Clear Spring Md. Date signed 9/22/48

Brown

RECEIVED
SEP 30 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 197

1. PLACE OF DEATH:

County Washington
City or town Cascade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Ritchie Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County St. Howard
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main St
(If rural, give LOCATION)
2. (a) If veteran, name war ✓

3. (a) FULL NAME

John Wickers
4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 12/14/77
6. (c) If alive, give age _____ years

8. AGE: Years 70 Months 8 Days 28 It less than one day _____ hrs. _____ min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation none given

11. Industry or business

12. Name Dietrich Wickers
13. Birthplace Germany
14. Maiden name Katherine Von Hoed
15. Birthplace Germany

16. Informant Hospital Records
Address Cascade Md

17. Burial (Date rec'd by registrar) 9-14-48
(Burial, cremation, or removal, Which?) Date thereof _____ month _____ day _____ year
Cemetery or crematory Good Shepherd
Location Ellicott City Md

18. Funeral director L. B. Sigmonothorn
Address Ellicott City Md

19. 9-14- 19 48 John B. Loughman Registrar
(Date rec'd by registrar) Sept 21-48 Geo H. Loughman

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 19 48 at 2:20 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/8 19 48 to 9/12 19 48
and that I last saw him alive on 9/12/48

Immediate cause of death Carcinoma of left auricle DURATION ?

Due to _____

Due to _____

Other conditions Aneurysm of aorta with rupture
Em. arteriosclerosis + senility (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Tom Armstrong, M.D. M. D. or other _____

Address Ritchie Hosp. Md. Date signed 9/17/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 28 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 903

1. PLACE OF DEATH:

County Washington
City or town Rural Clearspring R.F.D.2.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76 Years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?...

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Rural Clearspring R.F.D.2.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

Katherine Barbara Wiley

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1871. 6. (c) If alive, give age years

8. AGE: Years 76 Months 10 Days 17 If less than one day hrs. min.

9. Birthplace Big Pool Md. Washington.
(Town, county, and state)

10. Usual occupation Housewife.
Home.

11. Industry or business

12. Name Jacob Mills.
13. Birthplace Big Pool Md.
14. Maiden name Mary Kensel.
15. Birthplace Big Pool Md.

16. Informant Mrs. Ada Grove.
Address Big Pool Md. R.F.D.

17. Burial. Date thereof Oct 2 1948.
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Park Head.
Location Near Clearspring Md.

18. Funeral director Edith V. Leaf.
Address Williamsport Md

19. Oct 1 48 Joseph M. Munn
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 29, 1948 19. at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 28, 1948 19. to SEPT. 29, 1948
and that I last saw h. ER alive on SEPT. 29, 1948 19.

Immediate cause of death CEREBRAL HEMORRHAGE DURATION 12 HRS.

Due to HYPERTENSIVE CARDIOVASCULAR
RENAL DISEASE ?

Due to THYROTOXICOSIS ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NONE Date of op.

Autopsy results NONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lincoln Robert Cole M. D. Clear Spring Md
Address Date signed 10-1-48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 5 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 09764 502

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Funkstown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Grant Wyand

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Etta (Rohrer) Wyand

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 18648. AGE: Years 84 Months 0 Days 0 If less than one day _____ hrs. _____ min.9. Birthplace Keedysville-Wash.-Md
(Town, county, and state)10. Usual occupation Retired Merchant

11. Industry or business

12. Name Frederick Wyand13. Birthplace Eakles Mill - Md14. Maiden name Lydia Eckard15. Birthplace Frederick County16. Informant Mr. Earl WhitmoreAddress Funkstown, Md17. Burial Date thereof Sept. 6, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fair-ViewLocation Keedysville, Md18. Funeral director R. I. EarnshawAddress Keedysville, Md19. Sept 3 48 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1948 at 1:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3, 1948 to Sept. 3, 1948 and that I last saw him alive on Sept. 3, 1948Immediate cause of death Bronchopneumonia DURATION 3 daysDue to Cerebral Arteriosclerosis & mental deterioration 3 yearsOther conditions Cholelithiasis 10 years
Post-operative Appendicitis 3 weeks
(Include pregnancy within 3 months of death)Major findings of operations Cholelithiasis Date of op. 8-21-48Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William W. A. W. W. W. M. D. or other _____Address Hagerstown, Maryland Date signed 9/3/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 6 1948

BUREAU V. S.